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is no longer an inpatient in the hospital and is dissatisfied with this determination, the determination is subject to the general claims appeal process.

§ 405.1208 Hospital requests expedited QIO review.

(a) *General rule.* If the hospital (acting directly or through its utilization review committee) believes that the beneficiary does not require further inpatient hospital care but is unable to obtain the agreement of the physician, it may request an expedited determination by the QIO.

(b) *Procedures hospital must follow.* (1) The hospital must (acting directly or through its utilization review committee) notify the beneficiary (or his or her representative) that it has requested that review.

(2) The hospital must supply any pertinent information the QIO requires to conduct its review and must make it available by phone or in writing, by close of business of the first full working day immediately following the day the hospital submits the request for review.

(c) *Procedures the QIO must follow.* (1) The QIO must notify the hospital that it has received the request for review and must notify the hospital if it has not received all pertinent records.

(2) The QIO must examine the pertinent records pertaining to the services.

(3) The QIO must solicit the views of the beneficiary in question.

(4) The QIO must make a determination and notify the beneficiary, the hospital, and physician within 2 working days of the hospital's request and receipt of any pertinent information submitted by the hospital.

(d) *Notice of an expedited determination.* (1) When a QIO issues an expedited determination as stated in paragraph (c)(4) of this section, it must notify the beneficiary, physician, and hospital of its decision, by telephone and subsequently in writing.

(2) A written notice of the expedited initial determination must contain the following:

- (i) The basis for the determination;
- (ii) A detailed rationale for the determination;
- (iii) A statement explaining the Medicare payment consequences of the

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expedited determination and date of liability, if any; and

(iv) A statement informing the beneficiary of his or her appeal rights and the timeframe for requesting an appeal.

(e) *Effect of an expedited determination.* The expedited determination under this section is binding upon the beneficiary, physician, and hospital, except in the following circumstances:

(1) *When a beneficiary remains in the hospital.* If the beneficiary is still an inpatient in the hospital and is dissatisfied with this determination, he or she may request a reconsideration according to the procedures described in § 405.1204. The procedures described in § 405.1204 will apply to reconsiderations requested under this section. If the beneficiary does not make a request in accordance with paragraph (d)(1) of this section, the timeframes described in § 405.1204(c)(3), the escalation procedures described in § 405.1204(c)(5), and the coverage rule described in § 405.1204(f) will not apply.

(2) *When a beneficiary is no longer an inpatient in the hospital.* If the beneficiary is no longer an inpatient in the hospital and is dissatisfied with this determination, this determination is subject to the general claims appeal process.

Subparts K–Q [Reserved]

Subpart R—Provider Reimbursement Determinations and Appeals

AUTHORITY: Secs. 205, 1102, 1814(b), 1815(a), 1833, 1861(v), 1871, 1872, 1878, and 1886 of the Social Security Act (42 U.S.C. 405, 1302, 1395f(b), 1395g(a), 1395l, 1395x(v), 1395hh, 1395ii, 1395oo, and 1395ww).

SOURCE: 39 FR 34515, Sept. 26, 1974, unless otherwise noted. Redesignated at 42 FR 52826, Sept. 30, 1977.

§ 405.1801 Introduction.

(a) *Definitions.* As used in this subpart:

Administrator means the Administrator or Deputy Administrator of CMS.

Administrator's review means that review provided for in section 1878(f) of

the Act (42 U.S.C. 1395oo(f)) and § 405.1875.

Board means the Provider Reimbursement Review Board established in accordance with section 1878 of the Act (42 U.S.C. 1395oo) and § 405.1845.

Board hearing means that hearing provided for in section 1878(a) of the Act (42 U.S.C. 1395oo(a)), and § 405.1835.

Date of filing and *date of submission of materials* mean the day of the mailing (as evidenced by the postmark) or hand-delivery of materials, unless otherwise defined in this subpart.

Date of receipt means the date on the return receipt of "return receipt requested" mail, unless otherwise defined in this subpart.

Intermediary determination means the following:

(1) With respect to a provider of services that has filed a cost report under §§ 413.20 and 413.24(f) of this chapter, the term means a determination of the amount of total reimbursement due the provider, pursuant to § 405.1803 following the close of the provider's cost reporting period, for items and services furnished to beneficiaries for which reimbursement may be made on a reasonable cost basis under Medicare for the period covered by the cost report.

(2) With respect to a hospital that receives payments for inpatient hospital services under the prospective payment system (part 412 of this chapter), the term means a determination of the total amount of payment due the hospital, pursuant to § 405.1803 following the close of the hospital's cost reporting period, under that system for the period covered by the determination.

(3) For purposes of appeal to the Provider Reimbursement Review Board, the term is synonymous with the phrases "intermediary's final determination" and "final determination of the Secretary", as those phrases are used in section 1878(a) of the Act.

(4) For purposes of § 405.376 concerning claims collection activities, the term does not include an action by CMS with respect to a compromise of a Medicare overpayment claim, or termination or suspension of collection action on an overpayment claim, against a provider or physician or other supplier.

Intermediary hearing means that hearing provided for in § 405.1809.

(b) *General rule*—(1) *Providers*. The principles of reimbursement for determining reasonable cost and prospective payment are contained in parts 413 and 412, respectively, of this chapter. In order to be reimbursed for covered services furnished to Medicare beneficiaries, providers of services are obliged to file cost reports with their intermediaries as specified in § 413.24(f) of this chapter. Where the term "provider" appears in this subpart, it includes hospitals paid under the prospective payment system for purposes of applying the appeal procedures described in this subpart to those hospitals.

(2) *Other entities participating in Medicare Part A*. In addition to providers of services whose status as such is indicated in the Act, there are entities (such as health maintenance organizations) that do not meet the statutory test for providers of services, which may also participate in Medicare. These entities are required to file periodic cost reports and are reimbursed on the basis of information furnished in the reports. Although the entities do not qualify for Board review, the rules as set forth in this subpart with respect to intermediary hearings are applicable to the entities to the maximum extent possible, for cost-reporting periods ending on or after December 31, 1971, where the amount of program reimbursement in controversy is at least \$1,000.

(c) *Effective dates*. (1) Except as provided in paragraphs (c)(2) and (c)(3) of this section or in § 405.1885(e), this subpart applies to all cost reporting periods ending on or after December 31, 1971, for which reimbursement may be made on a reasonable cost basis.

(2) Sections 405.1835 to 405.1877 apply only to cost reporting periods ending on or after June 30, 1973, for which reimbursement may be made on a reasonable cost basis.

(3) With respect to hospitals under the prospective payment system (see part 412 of this chapter), the appeals procedures in §§ 405.1811 to 405.1877 that

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apply become applicable with the hospital's first cost reporting period beginning on or after October 1, 1983.

[39 FR 34515, Sept. 26, 1974. Redesignated at 42 FR 52826, Sept. 30, 1977, as amended at 48 FR 39834, Sept. 1, 1983; 48 FR 45773, Oct. 7, 1983; 49 FR 322, Jan. 3, 1984; 49 FR 23013, June 1, 1984; 51 FR 34793, Sept. 30, 1986; 61 FR 63749, Dec. 2, 1996]

§ 405.1803 Intermediary determination and notice of amount of program reimbursement.

(a) *General requirement.* Upon receipt of a provider's cost report, or amended cost report where permitted or required, the intermediary must within a reasonable period of time (see § 405.1835(b)), furnish the provider and other parties as appropriate (see § 405.1805) a written notice reflecting the intermediary's determination of the total amount of reimbursement due the provider. The intermediary must include the following information in the notice, as appropriate:

(1) *Reasonable cost.* The notice must—

(i) Explain the intermediary's determination of total program reimbursement due the provider on the basis of reasonable cost for the reporting period covered by the cost report or amended cost report; and

(ii) Relate this determination to the provider's claimed total program reimbursement due the provider for this period.

(2) *Prospective payment.* With respect to a hospital that receives payments for inpatient hospital services under the prospective payment system (see part 412 of this chapter), the intermediary must include in the notice its determination of the total amount of the payments due the hospital under that system for the cost reporting period covered by the notice. The notice must explain (with appropriate use of the applicable money amounts) any difference in the amount determined to be due, and the amounts received by the hospital during the cost reporting period covered by the notice.

(b) *Requirements for intermediary notices.* The intermediary must include in each notice appropriate references to law, regulations, CMS Rulings, or program instructions to explain why the intermediary's determination of the

amount of program reimbursement for the period differs from the amount the provider claimed. The notice must also inform the provider of its right to an intermediary or Board hearing (see §§ 405.1809, 405.1811, 405.1815, 405.1835, and 405.1843) and that the provider must request the hearing within 180 days after the date of the notice.

(c) *Use of notice as basis for recoupment of overpayments.* The intermediary's determination contained in its notice is the basis for making the retroactive adjustment (required by § 413.64(f) of this chapter) to any program payments made to the provider during the period to which the determination applies, including recoupment under § 405.373 from ongoing payments to the provider of any overpayments to the provider identified in the determination. Recoupment is made notwithstanding any request for hearing on the determination the provider may make under § 405.1811 or § 405.1835.

[48 FR 39834, Sept. 1, 1983, as amended at 49 FR 322, Jan 3, 1984; 51 FR 34793, Sept. 30, 1986; 61 FR 63748, Dec. 2, 1996]

§ 405.1804 Matters not subject to administrative and judicial review under prospective payment.

Neither administrative nor judicial review is available for controversies about the following matters:

(a) The determination of the requirement, or the proportional amount, of any budget neutrality adjustment in the prospective payment rates.

(b) The establishment of—

(1) Diagnosis related groups (DRGs);

(2) The methodology for the classification of inpatient discharges within the DRGs; or

(3) Appropriate weighting factors that reflect the relative hospital resources used with respect to discharge within each DRG.

[49 FR 322, Jan. 1, 1984]

§ 405.1805 Parties to intermediary determination.

The parties to the intermediary's determination are the provider and any other entity found by the intermediary